



State of Connecticut

Office of Health Care Access

Letter of Intent/Waiver Form

Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

| | Applicant One | Applicant Two |
|--|---|---------------|
| Full legal name | Orthopedic Associates Surgery Center, LLC | |
| Doing Business As | Orthopedic Associates Surgery Center | |
| Name of Parent Corporation | N/A | |
| Mailing Address, if Post Office Box, include a street mailing address for Certified Mail | 1111 Cromwell Avenue, Suite 100 Rocky Hill, CT 06067 | |
| Applicant type (e.g., profit/non-profit) | P | |
| Contact person, including title or position | Mr. Timothy Taylor Practice Administrator | |
| Contact person's street mailing address | 85 Seymour Street, Suite 607 Hartford, CT 06106 | |

| | | |
|--|--|--|
| Contact person's phone #, fax # and e-mail address | Phone: (860) 549-3210 Fax: (960) 241-1177 Email: <u>TTayloroah@aol.com</u> | |
|--|--|--|

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Operating Room Configuration

b. Type of Proposal, please check all that apply:

☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc)

☐ Replacement

☐ Additional (F, S, Fnc)

☒ Expansion (F, S, Fnc)

☐ Relocation

☐ Service Termination

☐ Bed Addition

☐ Bed Reduction

☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost greater than \$ 1,000,000

☐ Equipment Acquisition greater than \$ 400,000

☐ New

☐ Replacement

☐ Major Medical

☐ Imaging

☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$1,000,000

c. Location of proposal (Town including street address):

1111 Cromwell Avenue, Rocky Hill, CT 06067

d. List all the municipalities this project is intended to serve:

The current service area of the facility, which is the greater Hartford area, including all municipalities where the physician/owners' patients reside

- e. Estimated starting date for the project: September 1, 2006

- f. Type of project: 11 (Fill in the appropriate number(s) from page 7 of this form)

Number of Beds (to be completed if changes are proposed)

| Type | Existing Staffed | Existing Licensed | Proposed Increase (Decrease) | Proposed Total Licensed |
|------|------------------|-------------------|------------------------------|-------------------------|
| | | | | |
| | | | | |

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Capital Expenditure: \$ 459,300.00
- b. Please provide the following breakdown as appropriate:

| | |
|---------------------------------------|---------------------|
| Construction/Renovations | \$ 75,000.00 |
| Medical Equipment (Purchase) | 290,100.00 |
| Imaging Equipment (Purchase) | N/A |
| Non-Medical Equipment (Purchase) | 94,200.00 |
| Sales Tax | (included) |
| Delivery & Installation | (included) |
| Total Capital Expenditure | \$459,300.00 |
| Fair Market Value of Leased Equipment | |
| Total Capital Cost | \$459,300.00 |

Major Medical and/or Imaging equipment acquisition:

| Equipment Type | Name | Model | Number of Units | Cost per unit |
|----------------|------|-------|-----------------|---------------|
| | | | | |
| | | | | |

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

- ☒ Applicant's Equity
 ☐ Lease Financing
 ☐ Conventional Loan
☐ Charitable Contributions
 ☐ CHEFA Financing
 ☐ Grant Funding
☐ Funded Depreciation
 ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

- Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
- What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
- Who is the current population served and who is the target population to be served?
- Identify any unmet need and how this project will fulfill that need.
- Are there any similar existing service providers in the proposed geographic area?
- What is the effect of this project on the health care delivery system in the State of Connecticut?
- Who will be responsible for providing the service?
- Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following:
(Please check all that apply)

- ☐ This request is for Replacement Equipment.
 - ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
 - ☐ The cost of the equipment is not to exceed \$2,000,000.
 - ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

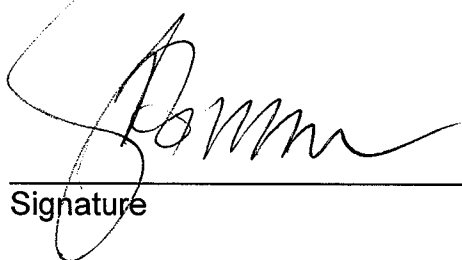
Applicant: Orthopedic Associates Surgery Center, LLC

Project Title: Operating Room Reconfiguration

I, Gordon A. Zimmermann, M.D., Chief Executive Officer
(Name) (Position – CEO or CFO)


of Orthopedic Associates Surgery Center, LLC being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Orthopedic Associates Surgery Center, LLC complies with
(Facility Name)

the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.


Signature

July 14, 2006
Date

Subscribed and sworn to before me on July 14, 2006


Notary Public/Commissioner of Superior Court

My commission expires: June 30, 2011

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

Section IV. Project Description

Orthopedic Associates Surgery Center, LLC (the "Center"), an ambulatory surgery center located in Rocky Hill, needs to reconfigure space within its existing outpatient surgical facility to meet the demands of patients of the physicians who perform services at the Center. Currently, the Center provides orthopedic surgical services and is used only by the physicians of Orthopedic Associates of Hartford ("OAH"). The project will not involve changing the scope of operations conducted at the Center, the location of the Center, nor will it involve expanding the space the Center occupies. It will continue to operate at 1111 Cromwell Avenue in Rocky Hill, CT. This project also will not affect the identity of the surgeons using the Center.

The Center has been established within the space indicated to the Office of Health Care Access ("OHCA") in lease agreements and other supporting documentation provided in Determination Report No. 03-301080DTR. Within that space, there are two fully staffed and licensed operating rooms and space utilized at present as a minor procedure room and an exam room. When the Center was originally designed and built, the space in question was incorporated within the Center so as to provide a means for expansion to meet patient needs. The two rooms that are the subject of this application were constructed consistent with physical plant requirements of the Public Health Code, so that only certain modest reconfigurations and minor equipment installations are necessary so as to make two rooms operating rooms that can be used in efficient and full coordination with the Center's existing two operating rooms. This expansion is necessary due to the volume and nature of services provided at the Center. Patient volumes have increased. Additionally, due to the more lengthy times for the performance of orthopedic procedures as compared to other types of ambulatory surgical procedures, the Center has found that it is unable to schedule additional surgeries in the existing operating rooms. Orthopedic facilities are well recognized as requiring much more time per case than is typical in non-orthopedic surgical settings, and the Center's volume exceeds benchmarks for orthopedic surgery centers.

The project will cost approximately \$459,000.00, and, as noted above, will not involve changing the footprint of the Center as presented to OHCA in prior submissions. The cost represents modest renovations and minor equipment purchases necessary to reconfigure the two rooms to be utilized in conjunction with the currently employed operating rooms at the Center. This project will not involve the acquisition of any major medical equipment. No new equipment is planned at this time other than minor equipment acquisitions that are part of the renovation plan. The additional rooms in question, as mentioned above, are currently utilized parts of the Center.

The project will allow for greater flexibility and efficiency in the operation of the Center. In addition, it will provide the ability to effectively coordinate activity in all the rooms and more expeditiously prepare and clean surgical venues. All this should lead to greater efficiency, patient access and satisfaction.

To reiterate, we are not seeking approval in this project for the provision of any services by any physicians outside of OAH. There also will not be any expansion of the roster of clinical services provided at the Center. The project involves no capital expenditures in excess of applicable thresholds and no acquisitions of major medical equipment. Also, no licensure categories will be added or changed.